Townsville Day Surgery

TOWNSVILLE DAY SURGERY RELEASE OF INFORMATION REQUEST FORM

PATIENT LABEL

Details of Patient:

Surname:	Given names:	
Name when last attended hospital: (if different to current name)		
Address: (past address if applicable)		Postcode:
Telephone:	Date of birth:	

Information to be released to:

Name:	
Relationship to patient:	☐ Treating Doctor ☐ Other, please specify _____
Hospital / Organisation:	
Postal address:	
Telephone:	Fax:
How and when information to be released:	Urgent: ☐ (within 2 hours) Phone: ☐ Fax: ☐ Mail: ☐ Non Urgent: ☐ Date Required: _____

Information required: Specify information required (eg. Specific diagnosis, test)

Operation report: ☐	
Clinical notes: ☐	
Investigations Results: ☐	
Other, please specify: ☐	

Patient consent to release of information: Provided: (please tick) Below ☐ or Separate ☐
(Request will not be processed without written consent of the patient, guardian or person responsible for patient)

I, _____ authorise the release of my (or my child's) relevant health information as specified above.
I understand I may revoke this consent at anytime except to the extent that action has already been taken on it and that it will expire automatically one (1) year from the date indicated below.

Signature: _____ Print name: _____ Date: _____
(Patient, Parent, Guardian or Person Responsible for Patient)

Please forward this form to relevant hospital for processing.
Townsville Day Surgery Pty Ltd
1 Martinez Avenue
West End QLD 4810

FOR INTERNAL USE ONLY UR NUMBER: CONSENT: YES NO	Request received by: _____ Request processed by: _____	Date: _____ Date: _____